EPI-SODE

EPIDEMIOLOGIC **S**URVEILLANCE **O**F COMMUNICABLE **D**ISEAS**E**

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Outbreak of Severe Acute Respiratory Syndrome -- Worldwide, 2003

Morbidity and Mortality Weekly Report

On February 11, the Chinese Ministry of Health notified WHO that 305 cases of acute respiratory syndrome of unknown etiology had occurred in six municipalities in Guangdong province in southern China during November 16, 2002 - February 9, 2003. The disease was characterized by transmission to health-care workers and household contacts; five deaths were reported. On February 26, a man aged 47 years who had traveled in mainland China and Hong Kong became ill with a respiratory illness and was hospitalized shortly after arriving in Hanoi, Vietnam. Health-care providers at the hospital in Hanoi subsequently developed a similar illness. The patient died on March 13 after transfer to an isolation facility in Hong Kong. During late February, an outbreak of a similar respiratory illness was reported in Hong Kong among workers at another hospital; this cluster was linked to a patient who had traveled previously to southern China. On March 12, WHO issued a global alert about the outbreak and instituted worldwide surveillance.

Among patients reported worldwide as of March 19, the disease has been characterized by rapid onset of high fever, myalgia, chills, rigor, and sore throat, followed by shortness of breath, cough, and radiographic evidence of pneumonia. The incubation period has generally been 3-5 days (range: 2-7 days). Laboratory findings have included thrombocytopenia and leukopenia. Many patients have had respiratory distress or severe pneumonia requiring hospitalization, and several have required mechanical ventilation. Of the 264 suspected and probable cases reported by WHO, nine (3%) persons have died. In addition, secondary attack rates of >50% have been observed among health-care workers caring for patients with SARS in both Hong Kong and Hanoi. Additional clinical and epidemiologic details are available from WHO at http://www.who.int/wer/pdf/2003/wer7812.pdf.

In the United States, initial diagnostic testing for persons with suspected SARS should include chest radiograph, pulse oximetry, blood cultures, sputum Gram stain and culture, and testing for viral respiratory pathogens, particularly influenza types A and B and respiratory syncytial virus. Clinicians should save any available clinical specimens (e.g., respiratory samples, blood, serum, tissue, and biopsies) for additional testing until diagnosis is confirmed. Instructions for specimen collection are available from CDC at http://www.cdc.gov/ncidod/sars/pdf/specimencollection-sars.pdf. Specimens should be forwarded to CDC by state health departments after consultation with the SARS State Support Team at the CDC Emergency Operations Center.

Clinicians evaluating suspected cases should use standard precautions (e.g., hand hygiene) together with airborne (e.g., N-95 respirator) and contact (e.g., gowns and gloves) precautions (http://www.cdc.gov/ncidod/sars/infectioncontrol.htm). Until the mode of transmission has been defined more precisely, eye protection also should be worn for all patient contact.

http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5211a5.htm

World Health Organization, March 20-21, 2003

Highly specialized testing of specimens from patients ill with SARS continues at top speed in top labs, expedited by electronic sharing of results.

Research is now focused on the Paramyxoviridae family of viruses. This family includes several well-known viruses, such as those causing mumps, measles and common respiratory ailments. It also includes a subfamily of viruses capable of infecting multiple animal species, including humans. This subfamily was implicated in the emergence during the 1990s of new and severe diseases in humans caused by Hendra and Nipah viruses. The virus jumped directly from animal hosts (horses and pigs) to humans. No person-to-person transmission was documented in outbreaks caused by either virus.

If a paramyxovirus is confirmed to be the cause, WHO will be in a much better position to recommend a treatment.

The antiviral drug, ribavirin, may be responsible for some degree of clinical improvement observed in critically ill patients in Hong Kong Special Administrative Region of China. Intensive and good supportive care have also been associated with improved prospects of recovery.

As of 21 March, 510 suspected and probable cases, including 10 deaths, have been reported from fifteen countries, including 13 under investigation in the U.S.

WHO is underscoring the need for continued vigilance. The world must protect itself against the widespread establishment of another new infectious disease.

http://www.who.int/csr/don/2003_03_20/en/print.html

http://www.who.int/csr/sarscountry/2003_03_21/en/

Smallpox Vaccination Clinic

On March 12 and 13, 2003 Clark County Health Department held Smallpox Vaccination Clinics. Ten public health and medical workers, who will participate in smallpox response teams, volunteered to be vaccinated. Vaccinees came from Oregon and Skamania, Clark and Cowlitz Counties. Public health staff from Skamania, Wahkiakum, Clark and Cowlitz Counties played key roles in staffing the clinic. Representatives from other organizations including Clark College, Vancouver Fire Department, Southwest Washington Medical Center Emergency Department, and Kaiser Permanente, took part in training and several participants received certification in smallpox vaccination technique. As of March 17, 2003 Washington State has vaccinated 232 persons: 148 females (64%), 84 males (36%); mean age 49 (range 21,69). As of this writing no adverse events have been reported.

Summary of Selected Notifiable Conditions
Clark and Skamania Counties, 2003 and 2002

Conditions	Clark County		Skamania County	
	Jan. Feb. 2003	Jan. Feb. 2002	**Jan. Feb. 2003**	Jan. Feb. 2002
HIV	9	10	0	0
Enteric Diseases				
Campylobacteriosis	8	*	0	0
E. coli O157:H7	*	*	0	0
Giardiasis	*	*	0	0
Salmonellosis	5	*	0	*
Shigellosis	*	*	0	0
Hepatitis				
Hepatitis A	*	0	0	0
Hepatitis B, acute	*	*	0	0
Hepatitis B, chronic	*	13	0	0
Hepatitis C (chronic)	13	14	0	*
Meningitis and Invasive Disease				
Hemophilus influenzae	0	*	0	0
Meningococcal disease	*	*	0	0
Streptococcus Group A	*	*	0	0
Sexually Transmitted Diseases				
Chlamydia trachomatis	141	112	0	0
Gonorrhea	17	28	0	5
Syphilis (primary & secondary)	0	*	0	*
Tuberculosis				
TB active disease	*	*	0	0
Latent TB infection +	19	22	0	0
Vaccine Preventable Diseases				
Measles	0	0	0	0
Mumps	0	0	0	0
Pertussis	13	*	0	0
Rubella (including congenital)	0	0	0	0

*<5 cases
+Patients followed by the health department

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